

**New Jersey Department of Health and Senior Services
Consumer and Environmental Health Services
PO Box 369
Trenton, NJ 08625-0369**

**REGISTRATION OF DRUG OR MEDICAL DEVICE MANUFACTURING
OR WHOLESALE DRUG OR MEDICAL DEVICE BUSINESS
(N.J.S.A. 24:6B)**

FEE: \$200 - Single location
\$500 - 2 or more locations in the State
\$50 - for each location in the State if the gross total annual business in drugs
does not exceed 3% of the gross total annual volume.

FOR STATE USE ONLY

☐ Check ☐ MO # _____
Date Received _____
Amount _____
Certificate No. _____
Registration # _____
Date Issued _____
Type: ☐ Mfg ☐ Whlse ☐ Other

*A check or money order, payable to "New Jersey Department of Health and Senior Services" must accompany this Registration.
Registration must be renewed prior to February 1 of each calendar year. NOTE: If more space is required, attach supplemental
sheets identifying each item corresponding to the number on this Registration form.*

SECTION I - IDENTIFICATION

1. Name Under Which Business is Conducted

2. Telephone Number
()

3. Mailing Address (Street, City, State, Zip Code)

4. List Locations of Drug or Medical Device Manufacturing or Wholesale Drug or Medical Device Business Conducted in this State:

A. Street Address: _____

City, State, Zip Code: _____

Responsible Person: _____

Telephone Number: _____

Activity Conducted: ☐ Mfg. ☐ Wholesale Distribution ☐ Other: _____

B. Street Address: _____

City, State, Zip Code: _____

Responsible Person: _____

Telephone Number: _____

Activity Conducted: ☐ Mfg. ☐ Wholesale Distribution ☐ Other: _____

C. Street Address: _____

City, State, Zip Code: _____

Responsible Person: _____

Telephone Number: _____

Activity Conducted: ☐ Mfg. ☐ Wholesale Distribution ☐ Other: _____

D. Street Address: _____

City, State, Zip Code: _____

Responsible Person: _____

Telephone Number: _____

Activity Conducted: ☐ Mfg. ☐ Wholesale Distribution ☐ Other: _____

5. Is this an Original Registration? ☐ Yes ☐ No

A. If No, date last registered: _____

6. If the registrant's business is not conducted from a location within the State, give the name of the individual appointed as resident New Jersey agent:

Name: _____

Locations from which NJ customers are serviced:

Address: _____

Address: _____

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(Continued)**

SECTION II - BUSINESS STRUCTURE

1. Provide the Names and Addresses of Owners, Partners, Officers and Agents:

A. SOLE OWNERSHIP

Name: _____
Street Address: _____
City, State, Zip Code: _____
Managing Proprietor: _____
Street Address: _____
City, State, Zip Code: _____

B. PARTNERSHIP

Partner: _____ Active: ☐ Yes ☐ No
Street Address: _____
City, State, Zip Code: _____
Partner: _____ Active: ☐ Yes ☐ No
Street Address: _____
City, State, Zip Code: _____
Partner: _____ Active: ☐ Yes ☐ No
Street Address: _____
City, State, Zip Code: _____
Partner: _____ Active: ☐ Yes ☐ No
Street Address: _____
City, State, Zip Code: _____

C. INCORPORATION *

Date of Incorporation: _____ State: _____

President: _____
Street Address: _____
City, State, Zip Code: _____
Vice-President: _____
Street Address: _____
City, State, Zip Code: _____
Secretary: _____
Street Address: _____
City, State, Zip Code: _____
Treasurer: _____
Street Address: _____
City, State, Zip Code: _____
NJ Registered Agent: _____
Street Address: _____
City, State, Zip Code: _____
Other Officer/Director: _____
Street Address: _____
City, State, Zip Code: _____

*In case of corporation with more than one Division, list Division Officers responsible for NJ operation.

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(Continued)**

D. OTHER (Designate type of business structure, if other than private ownership, partnership or corporation)

Type of Structure: _____

Responsible Principal (Non-Administrative): _____

Title: _____

Street Address: _____

City, State, Zip Code: _____

Responsible Principal (Non-Administrative): _____

Title: _____

Street Address: _____

City, State, Zip Code: _____

Administrator (Active in Business): _____

Title: _____

Street Address: _____

City, State, Zip Code: _____

Administrator (Active in Business): _____

Title: _____

Street Address: _____

City, State, Zip Code: _____

SECTION III - RECEIPT OF ORDERS SERVED

1. List the names and addresses of individuals, resident in the State, upon whom orders of the Commissioner may be served:

A. Name: _____

Street Address: _____

City, State, Zip Code: _____

B. Name: _____

Street Address: _____

City, State, Zip Code: _____

SECTION IV - DESCRIPTION OF BUSINESS/PRODUCTS

1. Are you engaged in inter-state commerce? ☐ Yes ☐ No
2. Indicate which of the following products and/or activities are conducted at each of the locations you listed in Question 4, Section I, Page 1, by checking the appropriate box:

	Location A	Location B	Location C	Location D
A. prescription drugs which fall under the Federal Prescription Drug Marketing Act of 1987, 21 U.S.C. 351, 353, 371 and 374 and C.F.R. 205	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. non-prescription, non-legend or over-the-counter (OTC) drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. medical devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. OTC veterinary drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. prescription veterinary drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. manufacturing, compounding, processing, wholesaling, jobbing, or distribution of controlled dangerous substances as defined by law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. transfilling of scuba oxygen tanks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. medical gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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(Continued)**

2. Describe the types of drug or medical device products manufactured for sale or wholesaled. In lieu of this, you may enclose a catalog or printed drug list of your products for this registration.

SECTION V – CERTIFICATION

To be signed by Individual Owner, Partner, Corporate President or Responsible Principal, whichever is applicable.

I (We) hereby certify that the information given in this Statement for Registration is true and complete to the best of my (our) information and belief.

Name	Title	
Signature		Date
Name	Title	
Signature		Date

SECTION V - CERTIFICATION BY CERTIFIED PUBLIC ACCOUNTANT OR PUBLIC ACCOUNTANT

I hereby certify that the gross total business in drugs of the above-named registrant does not exceed 3% of the gross total annual volume of the registrant's business.

Name of CPA or Public Accountant	Certificate Number
Address	
Signature	Date

Distribution: Original - NJDHSS Copy - Registrant